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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Denise Anh-Duong Phan, M.D.** **15243 Vanowen Street, Suite 101** **Van Nuys, CA 91405** **Physician's and Surgeon's Certificate No. G 73973,** Respondent.	Case No. 800-2017-035186 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 28, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 73973 to Denise Anh-Duong Phan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2019, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the board deems proper.

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patient 1.[1] The circumstances are as follows:

Patient 1

9. Patient 1 was a fifty-five year old female who treated with Respondent on or about March 28, 2011 through July 1, 2013.[2] Patient 1 was also being treated by multiple other medical specialists/consultants, and was taking various other medications during this time period. Per the autopsy report, Patient 1 died on July 4, 2013, from acute Fentanyl and Oxycodone toxicity.

10. During the first visit on March 28, 2011, Respondent saw Patient 1, who had various maladies, including Lupus, Fibromyalgia, Hypokalemia, Depression/Anxiety, Hepatitis, and pain. During this first visit, Respondent requested prior labs and records, and referred Patient 1 to a cardiologist and gastroenterologist. Respondent also prescribed to Patient 1 Norco 10/325 mg (a.k.a. as Hydrocodone), apparently for Patient 1's Fibromyalgia.[3]

11. During the second visit on June 9, 2011, Respondent refilled the Norco prescription for Patient 1, and added Valium for the patient. Per the record, Respondent also intended to recheck Patient 1 in two weeks.[4] On or about August 2011, Patient 1 also experienced a fall and was hospitalized. Thereafter, Patient 1 had complaints of severe back pain and anxiety. Records show that Respondent prescribed to Patient 1 Ambien (a sleep aid), Ativan (for anxiety), and refilled the patient's Norco (for pain).

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[1] The patient is identified by number to protect her privacy.

[2] These dates are based on the records which were available for review.

[3] It is not the standard of care to use narcotics for the initial treatment of Fibromyalgia.

[4] Dispensing #60 tablets of Norco by Respondent to Patient 1 on June 9, 2011 was a large amount, considering that the follow-up visit was intended to be only two weeks away. Moreover, per the records, on June 23, 2011, Respondent documented that Patient 1 was not taking the Norco during the past two weeks because she was trying to save the medications.

12. On or about November 9, 2011, Anthem Blue Cross Insurance Company wrote to Respondent alerting her that Patient 1 had been filling a large number of controlled substances by multiple providers within three months. Over that three-month period, Patient 1 was on opiates like Hydromorphone, Hydrocodone, and two different Benzodiazepines (Lorazepam and Temazepam) as well as Zolpidem (Ambien).[5]

13. On the last visit, July 1, 2013, Respondent changed Patient 1's analgesic and prescribed to Patient 1 a 100 mcg patch of Fentanyl, after being informed that Patient 1 had experienced a fall the previous day.[6] Respondent did not refer Patient 1 to a chronic pain specialist, and there appeared to be no change in Patient 1's PRN Oxycodone usage. Moreover, there appeared to be no documentation that Respondent had counselled Patient 1 about the safety concerns and potential side effects from Fentanyl.

14. These acts or omissions in the treatment of Patient 1, as described above, represents an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in her care of Patient 1 above. The circumstances are as follows:

16. The facts and circumstances in paragraphs 9 through 14, above, are incorporated by reference as if set forth in full herein.

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[5] Despite being alerted that Patient 1 was being prescribed multiple controlled substances by multiple providers and was filling the medications at different pharmacies, Respondent did not review the CURES database, and she indicated on the Anthem letter that the drug regimen was appropriate for Patient 1. In fact, records show that Respondent continued to refill/prescribe to Patient 1 multiple controlled substances (both opiates and benzodiazepines) to Patient 1, who was already on benzodiazepines, for almost two years after Respondent was alerted by Anthem. Of note, apparently Patient 1 had built up a tolerance for Norco (Hydrocodone) as early as January 17, 2012. However, instead of trying to wean the patient off the opioid, Respondent prescribed to Patient 1 another opioid (MS Contin or Oxycodone) to replace the Norco.

[6] Prescribing a Fentanyl patch should only be used in patients with stable opioid requirements. While Patient 1's analgesic regimen had not changed for several months, one could argue that her pain was not in a stable condition, and that the pain was likely exacerbated by her fall the previous day. Moreover, the dosing schedule used by Respondent in converting Patient 1 to the Fentanyl patch was too high.

17. Respondent also committed repeated negligent acts in her care of Patient 1 above. The circumstances are as follows:

Patient 1

18. Respondent departed from the standard of care by not adequately treating Patient 1's comorbid pain and affective disorders of depression and anxiety with benzodiazepines, and by failing to refer Patient 1 to a psychiatrist.

19. Respondent also failed to adequately document her medical decision-making regarding her use of benzodiazepines to treat Patient 1's comorbid depressive disorder, and regarding her use of opioids to treat the patient's pain. Respondent also failed to document a complete history of Patient 1's anxiety, and failed to adequately document Patient 1's pain disorder, including the history of the present illness and appropriate physical examinations. There was minimal documentation of the patient's chronic pain on all visits in the history. It did not include description of the pain, location, intensity, quality, onset/duration, along with variations/patterns/rhythms, exacerbators and alleviators. Previous diagnostic evaluations performed and results thereof were not documented. Moreover, Respondent failed to document the exploration of alternative non-narcotic medications and treatment, and no pain scales were documented on days of clinic visits.

20. These acts or omissions in the treatment of Patient 1, as described above, represent simple departures from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Records)

21. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of her care and treatment of Patient 1.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 73973, issued to Denise Anh-Duong Phan, M.D.;

2. Revoking, suspending or denying approval of Denise Anh-Duong Phan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Denise Anh-Duong Phan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 17, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant